

**Alameda County Behavioral Health Care Services,**

Mental Health Division

**Asian Community Mental Health Services**

**TREATMENT PLAN**

Initial (Check box if applicable)

Client's Name:

Birth Date:

Opening Episode Date:

PSP Client ID No.:

Reporting Unit:

From: \_\_\_\_\_ To: \_\_\_\_\_ (for 6-month treatment cycle)

**DIAGNOSIS** (Please complete all five Axes)

**Axis I: CLINICAL DISORDERS & Other Conditions that may be a Focus of Clinical Attention**

<u>Diagnostic Code</u>	<u>DSM IV Name</u>	(Primary)
_____	_____	
_____	_____	
_____	_____	

**Axis II: PERSONALITY DISORDERS, Mental Retardation**

<u>Diagnostic Code</u>	<u>DSM IV Name</u>
_____	_____

**Axis III: GENERAL MEDICAL CONDITIONS**

\_\_\_\_\_

**Axis IV: PSYCHOLOGICAL AND ENVIRONMENTAL PROBLEMS (Circle all that apply.)**

Please specify the stressors marked

Principal Stressor (mark 1)

- |   |       |                          |
|---|-------|--------------------------|
| A. Problems with primary support group.                     | _____ | <input type="checkbox"/> |
| B. Problems related to the social environment.              | _____ | <input type="checkbox"/> |
| C. Educational problems.                                    | _____ | <input type="checkbox"/> |
| D. Occupational problems.                                   | _____ | <input type="checkbox"/> |
| E. Housing problems.  | _____ | <input type="checkbox"/> |
| F. Economic problems.                                       | _____ | <input type="checkbox"/> |
| G. Problems with access to health care services.            | _____ | <input type="checkbox"/> |
| H. Problems related to interaction with legal system/crime. | _____ | <input type="checkbox"/> |
| I. Other psychosocial and environmental problems.           | _____ | <input type="checkbox"/> |
| J. Unknown/Unavailable                                      | _____ | <input type="checkbox"/> |

**Axis V: GLOBAL ASSESSMENT OF FUNCTIONING SCALE** Current Score: \_\_\_\_\_ Highest Past Year Score: \_\_\_\_\_

Diagnoses established by:	<input type="checkbox"/> N/A	on _____
	Licensed LPHA: Name, Title, (& Agency if Licensed LPHA is not a staff of ACMHS)	Date _____
OR jointly by a Licensed LPHA and a Waivered/Registered LPHA/Graduate Program intern or trainee	_____	on _____
	Waivered/Registered LPHA, Graduate Program Intern or Trainee: Name, Title	Date _____
_____	_____	on _____
Licensed LPHA: Name, Title	_____	Date _____

Client's **Service Necessity (SN)** Rating in the following areas indicate that the client has a significant functional impairment, or a probability of significant deterioration in an important area of functioning, or a probability that the child will not progress developmentally as individually appropriate. Client needs the level of treatment and/or services from this out-patient program in order to significantly diminish the impairment, prevent significant deterioration in an important area of life functioning, or allow the child to progress developmentally as individually appropriate.

	Low SN			High SN	
	1	2	3	4	5
A. Client is at risk of not having a permanent living arrangement, including being homeless or at risk of becoming homeless. (For children, at risk of out of home placement.)	<input type="checkbox"/>				
B. Client needs this level of care to prevent difficulties in education/employment/day/ social activities.	<input type="checkbox"/>				
C. Client does not have the ability to establish and maintain relationships including social support system.	<input type="checkbox"/>				
D. Client is unable to maintain physical/mental hygiene including management of own medication.(consider age appropriate.)	<input type="checkbox"/>				
E. Client exhibits psychotic symptoms, or suicidal ideation/acts or violent ideations/acts to persons or property.	<input type="checkbox"/>				
F. Client has a high risk of recurrence to a level of significant functional impairment.	<input type="checkbox"/>				

<b>Alameda County Behavioral Health Care Services,</b> Mental Health Division <b>Asian Community Mental Health Services</b> <b>TREATMENT PLAN</b> From: ___ To: ___ (for 6-month treatment cycle)	Client's Name: Birth Date: Opening Episode Date: PSP Client ID No.: Reporting Unit:
<b>2. Original Signs, Symptoms, Resulting Impairments, &amp; Onset of Sxs That Support DSM IV Diagnosis:</b>  	
<b>Current Signs, Symptoms, Resulting Impairments That Support DSM IV Diagnosis:</b>  	
<b>3. Risk Assessment/Reduction Plan: (Check and List Interventions.) -&gt; For interventions, see page 3.</b> <input type="checkbox"/> Suicidal/Self-Harm <input type="checkbox"/> Health <input type="checkbox"/> Violence <input type="checkbox"/> Not Applicable. <input type="checkbox"/> Other:	
<b>4. Strengths and Resources: (Note client's &amp; family's strengths &amp; resources with plans to utilize.):</b>  	
<b>5. Family Goals Participation in Client Plan: (If none, note reason.)</b>  	
<b>6. Special Needs and Plan:</b> <input type="checkbox"/> Linguistic <input type="checkbox"/> Cultural <input type="checkbox"/> Visual <input type="checkbox"/> Hearing <input type="checkbox"/> Handicapping Condition Plan: <input type="checkbox"/> Client will be served by _____ speaking bilingual/bicultural mental health professionals. <input type="checkbox"/> Client will be served by culturally responsive mental health professionals. <input type="checkbox"/> Other:	
<b>7. Estimated Duration of Treatment:</b>  	
<b>8. Prognosis:</b> <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
<b>9. Medication Regimen:</b> <input type="checkbox"/> No Prescribed Medication <input type="checkbox"/> See Medication Records <input type="checkbox"/> Prescribed by Outside MD (If box checked list medications with dosages and physician's name/phone #.)	
<b>10. Tentative Discharge Plan:</b> Clt will be discharged to <input type="checkbox"/> Family / <input type="checkbox"/> Community agency / <input type="checkbox"/> Lower level of providers / <input type="checkbox"/> PCP / <input type="checkbox"/> Psychiatric (med only) / <input type="checkbox"/> Mental health counseling / <input type="checkbox"/> Self / <input type="checkbox"/> Other (continue below)	
<b>11. Professional Discipline Responsible, Specific Service Type &amp; Frequency: Client will receive</b> <input type="checkbox"/> with supervision from Licensed LPHA.	
<b>12. Client's Goals:</b> <b>Long Term:</b> <hr/> <b>Short Term:</b> <hr/>	

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*Treatment Plan Instructions:* ① Address "Area of Need" that applies (e.g., Health, Living Arrangements, Daily Activities, Social Relationships, Symptom Mgt.) ② Define "Problem Statement" that shows service necessity with symptoms & functional impairment in measurable terms. ③ "Objectives" must be measurable with timeframes & baselines.

① AREA OF NEED:

② PROBLEM #: 1. STATEMENTS:

③ OBJECTIVE(S): WITHIN THE NEXT \_ MONTHS, CLIENT WILL

Date Objective Achieved:

① AREA OF NEED:

② PROBLEM #: 2. STATEMENTS:

③ OBJECTIVE(S): WITHIN THE NEXT \_ MONTHS, CLIENT WILL

Date Objective Achieved:

① AREA OF NEED:

② PROBLEM #: 3. STATEMENTS:

③ OBJECTIVE(S): WITHIN THE NEXT \_ MONTHS, CLIENT WILL

Date Objective Achieved:

*My signature (or e-signature) indicates that this treatment plan has been discussed with me in my primary language, that I have been offered a copy, and that I approve of the plan (unless otherwise indicated).*

Client's

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

\*Comments by client or clinician. If client does not approve plan, note reason(s):

If interpretation was provided, by whom, and relationship to client (if any):  
See below for signature(s) or attached e-signature page:

Treatment Plan developed by:

Clinician's Signature & title: \_\_\_\_\_

(Print name & title)

Licensed LPHA

Date: \_\_\_\_\_

Approved by Licensed

LPHA's Signature & title: \_\_\_\_\_

(Print name & title)

N/A

Date: \_\_\_\_\_

Approved by

Psychiatrist's Signature & title: \_\_\_\_\_

(Print name & title)

N/A

Date: \_\_\_\_\_

